# HIPAA Portability Provisions

*The Health Insurance Portability and Accountability Act (HIPAA) includes provisions of Federal law governing health coverage portability, health information privacy, administrative simplification, medical savings accounts, and long-term care insurance. The responsibility of the Department of Labor and the subject of this segment of the booklet are the law's portability requirements.*

*Some employment-based group health plans limit or deny coverage for health conditions because they are present prior to the date coverage begins (known as "preexisting condition exclusions"). HIPAA limits which types of conditions can be subject to a preexisting condition exclusion, sets a maximum preexisting condition exclusion period, and also allows individuals to receive credit for recent prior health coverage, reducing the time they can be excluded from a new employer's health plan for a preexisting condition. Among other things, this allows employees to switch jobs without permanently losing health coverage for a preexisting condition.*

*In addition to the preexisting condition exclusion provisions noted above, HIPAA's portability provisions affect group health plan coverage in the following ways:*

- *Require group health plans and health insurance issuers to provide certificates of prior health coverage;*
- *Provide certain individuals special enrollment rights in group health coverage when specific events occur, e.g., birth of a child (regardless of any open season);*
- *Prohibit discrimination in group health plan eligibility, benefits, and premiums based on specific health factors; and*
- *Guarantee that health coverage be available to, and can be renewed by, certain employers.*

*The law's portability requirements apply generally to group health plans with two or more participants who are current employees. However, if the coverage is insured, States may elect to regulate smaller groups. In addition, HIPAA does not apply to excepted benefits, such as certain dental and vision coverage.*

*HIPAA's portability provisions amended ERISA, the Internal Revenue Code, and the Public Health Service (PHS) Act. The agencies responsible for these laws are the U.S. Department of Labor, the Internal Revenue Service, and the U.S. Department of Health and Human Services, respectively.*

*The following sections address each of HIPAA's major requirements.*

# Preexisting Condition Exclusions

*HIPAA places strict limitations on a plan's ability to impose a preexisting condition exclusion. Specifically, HIPAA:*

- *Provides that any exclusion for a preexisting condition must relate to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 6-month period prior to an individual's enrollment date in the plan. (This is known as the "6-month look-back" rule.)*

- *Limits the maximum period a preexisting condition exclusion can be applied to an individual to 12 months (or 18 months for late enrollees). The period begins on the individual's enrollment date in the plan. (This is known as the "look-forward" rule).*

- *Reduces the 12- or 18-month maximum exclusion period by the number of days of an individual's prior "creditable coverage." (Most health coverage is "creditable coverage," as described in more detail on page 11).*

- *Provides that certain people and conditions can never be subject to a preexisting condition exclusion.*

- *Requires that health plans give a general notice disclosing that the plan applies a preexisting condition exclusion and a separate individual notice that informs an employee or their dependent of the specific exclusion that applies to them.*

*A model general notice is on page 77 and a model individual notice is on page 79.*

*Following are frequently asked questions about the limits on preexisting condition exclusions:*

### What is a preexisting condition exclusion?

A preexisting condition exclusion is any limitation or exclusion of benefits for a health condition because it was present before coverage begins, regardless of whether any medical advice, diagnosis, care, or treatment was recommended or received before that day. Some preexisting condition exclusions are designated in the plan documents. Others are not, but operate to exclude benefits because a condition arose before coverage began. For example, a dental exclusion that covers benefits in connection with accidental injury *if the injury occurred while the individual was covered under the plan*. The timing requirement in this example makes the exclusion a preexisting condition exclusion.

### Can any prior health condition be subject to a preexisting condition exclusion?

No. Only those conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period prior to an individual's enrollment date (often referred to as the "6-month look-back period") can be subject to a preexisting condition exclusion. The "enrollment date" is considered the first day of coverage under the plan; or if there is a waiting period, it is the first day of the waiting period. Typically the enrollment date is an individual's date of hire.

Consequently, if an individual had a medical condition in the past, but has not received any medical advice, diagnosis, care, or treatment for the condition within the 6 months prior to his/her enrollment date in the plan, the condition is not a preexisting condition to which an exclusion can be applied.

### Are there certain people or conditions that cannot be excluded from coverage under a preexisting condition exclusion?

Yes. Preexisting condition exclusions cannot be applied to pregnancy, whether or not the woman had previous coverage. In addition, exclusions cannot apply to a newborn, an adopted child under age 18, or a child under age 18 placed with a family or individual for adoption, as long as the child became covered under creditable coverage within 30 days of birth, adoption, or placement for adoption and does not incur a subsequent 63-day break in coverage. Finally, genetic information may not be treated as a preexisting condition in the absence of a diagnosis of a condition.

### My company's plan has a waiting period prior to enrollment. How does it impact our preexisting condition exclusion?

HIPAA does not prohibit a plan from having a waiting period before individuals become eligible for benefits. In fact, plans may have both a waiting period – the time that must pass before an employee or a dependent is eligible to enroll under the terms of the plan – *and* a preexisting condition exclusion.

If a plan has both a waiting period and a preexisting condition exclusion period, the maximum preexisting condition exclusion period begins when the waiting period begins. They must run concurrently.

## What is creditable coverage?

Creditable coverage is most health coverage and includes coverage under a group health plan (COBRA continuation coverage is included in this category), an HMO, an individual health insurance policy, Medicaid, or Medicare. An individual's prior creditable coverage reduces the maximum preexisting condition exclusion period that a group health plan can apply to that individual.

Creditable coverage does not include coverage consisting solely of "excepted benefits," such as coverage solely for limited-scope dental or vision benefits. (Excepted benefits are described in more detail on page 26.)

Days in a waiting period during which an individual has no other coverage are not considered creditable coverage, nor are these days taken into account when determining if there is a significant break in coverage. (A significant break in coverage generally occurs when an individual has no health coverage for 63 days or more.) Any health coverage an individual had before a significant break in coverage is not counted to reduce an exclusion period.

To illustrate: Suppose an individual had health coverage for 2 years followed by a break in coverage of 70 days and then resumed health coverage for 8 months. That individual would receive credit for 8 months of coverage but not for the 2 years of coverage prior to the break of 70 days, since it was more than 63 days.

## How does the plan determine the length of an individual's preexisting condition exclusion period?

The maximum length of a preexisting condition exclusion period is 12 months after the enrollment date (18 months in the case of a "late enrollee"). A late enrollee is an individual who enrolls in a plan other than on either: (1) the earliest date on which coverage can become effective under the terms of the plan, or (2) on a special enrollment date.

A plan must reduce this maximum period by the number of days of that individual's creditable coverage. However, a plan is not required to take into account any days of creditable coverage that precede a significant break in coverage.

A plan generally receives information about an individual's creditable coverage from a certificate furnished by a prior plan or health insurance issuer. However, individuals also may present other evidence of creditable coverage.

## What is the first thing a plan must do before imposing a preexisting condition exclusion period?

A health plan must distribute a general notice of its preexisting condition exclusion that includes:

- A statement that the plan has a preexisting condition exclusion and the terms of the exclusion period. This includes the length of the plan's look-back period regarding preexisting conditions, the maximum exclusion period (the look-forward period) under the plan, and how the plan will reduce the maximum period by creditable coverage.

- A description of the individual's right to demonstrate prior creditable coverage and prior waiting periods through a certificate or other means. This includes a description of the right to request a certificate from a prior plan or issuer and a statement that the current plan will assist in obtaining a certificate from the prior plan or issuer, if necessary.

- The person to contact (including address and telephone number) for obtaining additional information or assistance regarding the preexisting condition exclusion.

This notice must be distributed as part of the application materials for health benefits coverage. If the plan does not distribute such materials, the notice must be provided by the earliest date following a request for enrollment that the plan, acting in a reasonable and prompt fashion, can provide the notice. (See model general notice on page 77.)

## What are the next steps after an individual demonstrates creditable coverage?

When an individual presents evidence of creditable coverage (such as a certificate of creditable coverage), the plan must determine how much creditable coverage that individual has and the length of any remaining exclusion period.

A plan may not impose any limit on the amount of time that an individual has to present evidence of creditable coverage.

If an individual presents evidence of creditable coverage but does not have enough to offset the plan's entire preexisting condition exclusion period, then the plan must provide an individual notice of the preexisting condition exclusion period that will apply to that individual. The notice must include:

- The plan's determination (including the last day on which the exclusion for a preexisting condition applies);

- The basis for the determination (including the source and substance of any information on which the plan relied);

- An explanation of the individual's right to submit additional evidence of creditable coverage; and

- Any applicable appeals procedures.

### Can a plan change the determination in light of additional evidence?

The plan may modify its initial determination if it later determines than an individual does not have the creditable coverage previously claimed. In this circumstance, the plan must notify the individual of its new determination. Until this notice of the new determination is provided, the plan must approve access to medical services according to its initial determination.

## Evidence of Creditable Coverage

Group health plans are required to furnish a certificate of creditable coverage to an individual to document the individual's prior creditable coverage under the plan. This certificate can be used as evidence of creditable coverage for the individual's new group health plan to reduce the length of a preexisting condition exclusion period that might apply. The certificate must be provided free of charge and is given:

- Automatically (a) when an individual loses coverage under the plan or becomes entitled to elect COBRA continuation coverage, and (b) when an individual's COBRA continuation coverage ceases; and

- If requested, before that individual loses coverage or within 24 months of losing coverage.

(For more information on COBRA, see the U.S. Department of Labor's publication, *An Employer's Guide to Group Health Continuation Coverage under COBRA* at www.dol.gov/ebsa.)

Group health plans, in determining whether an exclusion period applies to a new employee or his/her dependents, must permit that employee (or dependents) to show prior health coverage, either by a certificate of creditable coverage, or in the absence of a certificate, by producing other evidence of creditable coverage. This evidence can include pay stubs showing a deduction for health insurance, explanation of benefits forms (EOBs), or verification by a doctor or a former health care benefits provider that the employee or dependent had prior health insurance coverage.

## Do plans that do not impose a preexisting condition exclusion period have to provide certificates?

Yes. Individuals previously covered under these plans may need to demonstrate this prior coverage, if they move to a new group health plan or individual health insurance coverage.

## Are plans required to issue certificates of creditable coverage to dependents?

Yes. A plan must make reasonable efforts to collect the necessary information for dependents and issue a certificate of creditable coverage for the dependent. If the coverage information for a dependent is the same as for the employee, the plan may issue one certificate with both the employee and dependent information. If the information is not identical, it may still be provided on one certificate, if the certificate provides all the required information for each individual separately and includes a statement that the information is not identical.

However, an automatic certificate for a dependent is not required to be issued until the plan knows (or, making reasonable efforts, should know) of the dependent's loss of coverage. Dependent information can be collected annually, such as during an open enrollment period.

## When must group health plans provide certificates?

It depends on the event that triggers the certificate.

- For an individual who is entitled to elect COBRA continuation coverage, the automatic certificate must be provided no later than when a election notice is required to be provided for a qualifying event under COBRA (generally 44 days). For more information on the COBRA notice requirements, see *An Employer's Guide to Group Health Continuation Coverage Under COBRA* at www.dol.gov/ebsa.

- For an individual who loses coverage under a group health plan but is not entitled to elect COBRA continuation coverage, the automatic certificate must be provided within a reasonable time after coverage ceases.

- For an individual who loses COBRA continuation coverage, the automatic certificate should be provided within a reasonable time after COBRA continuation coverage ceases (or after the expiration of any grace period for the nonpayment of COBRA premiums).

- For an individual requesting a certificate, it should be provided at the earliest time that the plan, acting in a reasonable and prompt fashion, could provide it.

### What information must be included on the certificate?

Certificates of creditable coverage currently must include:

- Date issued;
- Name of plan;
- Individual's name and ID;
- Plan administrator's name, address, and phone number;
- Phone number for further information;
- Individual's creditable coverage information; and
- An educational statement explaining HIPAA, including:
  - The preexisting condition exclusion rules;
  - Special enrollment rights;
  - The prohibitions against discrimination based on any health factor;
  - The right to individual health coverage;
  - The fact that State law may require issuers to provide additional protections to individuals in that State; and
  - Where to get more information.

A model certificate is available (see page 73).

***Note***: The Departments of Labor, the Treasury, and Health and Human Services issued proposed rules regarding the coordination of the HIPAA portability rules with the Family and Medical Leave Act (FMLA). The proposed rules include a revised educational statement for the HIPAA certificate with new model language to explain this coordination. Some plans may wish to avoid revising their certificates when the proposed rules become final, and therefore, use the model certificate under the proposed rules, which includes FMLA language (on page 75). Check www.dol.gov/ebsa under "Laws & Regulations" periodically for the publication of the final rule.

### In reporting an individual's creditable coverage information, what is the minimum period of time that should be covered by the certificate?

It will depend on whether the certificate is issued automatically or upon request:

- For a certificate that is issued automatically, the certificate should reflect the most recent period of continuous coverage.

- For a certificate that is issued upon request, the certificate should reflect each period of continuous coverage ending within 24 months prior to the date of the request. A separate certificate may be provided for each period of coverage if there is more than one.

However, the certificate does not have to reflect more than 18 months of creditable coverage that is not interrupted by a break in coverage of 63 days or more. A certificate should also include either a statement that an individual has at least 18 months of creditable coverage or the date creditable coverage (and any waiting period for coverage) began. The certificate should also include the date coverage ended or state that coverage is continuing.

## Can creditable coverage information be transferred by telephone?

Yes, if the individual involved, his/her new plan, and the old plan all agree, the information may be transferred by phone. Individuals are entitled to request a written certificate for their records when coverage information is provided by phone.

## Can a plan contract with a health insurance issuer to provide certificates?

Yes, a plan and issuer can make an agreement that the issuer will be responsible for providing the certificates. While the issuer is liable for noncompliance with the certificate requirements, the plan administrator has the duty to monitor the issuer's compliance with the certificate requirements under the contract.

In addition, if any entity (including a third-party administrator) provides a certificate to an individual, no other party is required to do so.

# Special Enrollment

*Group health plans are required to provide special enrollment periods during which individuals who previously declined health coverage for themselves and their dependents may be allowed to enroll (regardless of any open enrollment period).*

*Special enrollment rights can occur when:*

- *An individual loses eligibility for coverage under a group health plan or other health insurance coverage (such as an employee and his/her dependents' loss of coverage under the spouse's plan) or when an employer terminates contributions toward health coverage;*

- *An individual becomes a new dependent through marriage, birth, adoption, or being placed for adoption.*

*Employees must receive a description of special enrollment rights on or before the date they are first offered the opportunity to enroll in the group health plan (see model notice on page 80).*

### Can the special enrollment notice be provided in the summary plan description (SPD)?

Yes, if the SPD is provided to the employee at or before the time the employee is initially offered the opportunity to enroll in the plan. If the SPD is provided at a later time, the special enrollment notice should be provided separately (for example, as part of the application for coverage).

### Upon loss of eligibility for health coverage or termination of employer contributions for health coverage, what are a plan's obligations to offer special enrollment?

When an employee or dependent loses eligibility for coverage under any group health plan or health insurance coverage, or if employer contributions toward group health plan coverage cease, a special enrollment opportunity may be triggered. The employee or dependent must have had health coverage when the group health plan benefit package was previously declined. If the other coverage was COBRA continuation coverage, special enrollment need not be made available until the COBRA coverage is exhausted.

For example, if an employee's spouse declined coverage when previously offered due to coverage under her own employer's plan, she and the employee must be offered a special enrollment opportunity when her coverage ceases under that plan or her employer terminates contributions to that plan.

Another example is if an employer offering two benefit package options, an HMO and an indemnity option, eliminates coverage under the indemnity option. Employees, spouses, and other dependents must be offered a special enrollment opportunity in the HMO option (and may also be eligible to special enroll in any other plan for which they are otherwise eligible, such as any plan offered by the spouse's employer).

### What are examples of a loss of eligibility for coverage?

Some examples of events that cause an individual to lose eligibility for health coverage (there are other reasons as well):

- Divorce or legal separation;
- A dependent is no longer considered a dependent under the plan because of age, work, or school status;
- Death of the employee covered by the plan;
- Termination of employment;
- Reduction in the number of hours of employment;
- The plan decides to no longer offer any benefits to a class of similarly situated individuals;
- An individual incurs a claim that would meet or exceed a lifetime limit on all benefits; or
- An individual in an HMO or other arrangement no longer resides, lives, or works in the service area.

### If an employer terminates all contributions to a group health plan, but individuals have the option to continue coverage and pay 100 percent of the cost themselves, would these individuals still have a special enrollment right because the employer has terminated contributions?

Yes. If all employer contributions have ended, individuals covered under the plan would have a special enrollment right, regardless of their option to continue coverage under the plan by paying the full cost of coverage.

### If a plan has to offer a special enrollment period upon loss of eligibility or termination of employer contributions, how long must the special enrollment period run?

The plan has to provide at least 30 days for the employee or dependent to request coverage after the loss of other coverage or termination of employer contributions.

If an individual does request coverage within the 30-day period, the plan must make the coverage effective no later than the first day of the first calendar month beginning after the date the plan receives the enrollment request.

### Upon marriage, birth, adoption, or placement for adoption, what are a plan's obligations to offer special enrollment?

Employees, as well as their spouses and dependents, may have special enrollment rights after a marriage, birth, adoption, or placement for adoption. In addition, new spouses and new dependents of retirees in a group health plan also may have special enrollment rights after these events.

The plan has to provide at least 30 days for the employee or dependents to request coverage after the occurrence of one of these events.

If the event was a marriage, the coverage is required to be effective no later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the plan.

In the case of birth, adoption, or placement for adoption, coverage is required to be effective no later than the date of the event.

### Can special enrollees be treated as late enrollees when imposing a preexisting condition exclusion or benefits offered under the plan?

A special enrollee may not be treated as a late enrollee (see page 11). In fact, the plan must treat special enrollees the same as similarly situated individuals who enroll when first eligible.

In addition, a newborn, adopted child, or child placed for adoption generally cannot be subject to a preexisting condition exclusion period if the child is covered under creditable coverage within 30 days of birth, adoption, or placement for adoption.

# Nondiscrimination Requirements

*Under HIPAA, individuals may not be denied eligibility or continued eligibility to enroll in a group health plan based on any health factors they may have. In addition, an individual may not be charged more for coverage than any similarly situated individual is being charged based on any health factor.*

***Note:*** *Compliance with HIPAA's nondiscrimination provisions does not in any way reflect compliance with any other provision of ERISA (including COBRA and ERISA's fiduciary provisions). Nor does it reflect compliance with other State or Federal laws (such as the Americans with Disabilities Act).*

### What are the "health factors"?

They are:

- health status;
- medical condition, including both physical and mental illnesses;
- claims experience;
- receipt of health care;
- medical history;
- genetic information;
- evidence of insurability; and
- disability.

The term "evidence of insurability" includes conditions arising from acts of domestic violence, as well as participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

### Can a group health plan require an individual to pass a physical examination in order to be eligible to enroll in the plan?

No. A group health plan may not require an individual to pass a physical exam for enrollment, even if the individual is a late enrollee.

### Can a plan require an individual to complete a health care questionnaire in order to enroll?

Yes, provided that the health information is not used to deny, restrict, or delay eligibility or benefits, or to determine individual premiums.

## Can plans exclude or limit benefits for certain conditions or treatments?

Group health plans may exclude coverage for a specific disease, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination that the benefits are experimental or medically unnecessary – but only if the benefit restriction applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on a health factor they may have. (Plan amendments that apply to all individuals in a group of similarly situated individuals and that are effective no earlier than the first day of the next plan year after the amendment is adopted are not considered to be directed at individual participants and beneficiaries.)

## Can a plan deny benefits otherwise provided for the treatment of an injury based on the source of that injury?

If the injury results from a medical condition or an act of domestic violence, a plan may not deny benefits for the injury – if it is an injury the plan would otherwise cover.

For example, a plan may not exclude coverage for self-inflicted injuries (or injuries resulted from attempted suicide) if the individual's injuries are otherwise covered by the plan and if the injuries are the result of a medical condition (such as depression).

However, a plan may exclude coverage for injuries that do not result from a medical condition or domestic violence, such as injuries sustained in high risk activities (for example, bungee jumping). But the plan could not exclude an individual from *enrollment* for coverage because the individual participated in bungee jumping.

## Can a plan charge individuals with histories of high claims more than similarly situated individuals based on their claims experience?

No. Group health plans cannot charge an individual more for coverage than other similarly situated individuals based on any health factor.

## How are groups of similarly situated individuals determined?

Distinctions among groups of similarly situated participants in a health plan must be based on bona-fide employment-based classifications consistent with the employer's usual business practice. Distinctions cannot be based on any of the health factors noted earlier.

For example, part-time and full-time employees, employees working in different geographic locations, and employees with different dates of hire or lengths of service can be treated as distinct groups of similarly situated individuals, with different eligibility provisions, different benefit restrictions, or different costs, provided the distinction is consistent with the employer's usual business practice.

In addition, a plan generally may treat participants and beneficiaries as two separate groups of similarly situated individuals. The plan also may distinguish between beneficiaries based on, for example, their relationship to the plan participant (such as spouse of dependent child) or based on the age or student status of dependent children.

In any case, a plan cannot create or modify a classification directed at individual participants or beneficiaries based on one or more of the health factors.

### Is it permissible for a health insurance issuer to charge a higher premium to one group health plan (or employer) that covers individuals, some of whom have adverse health factors, than it charges another group health plan comprised of fewer individuals with adverse health factors?

Yes. In fact, HIPAA does not restrict a health insurance issuer from charging a higher rate to one group health plan (or employer) over another. An issuer may take health factors of individuals into account when establishing blended, aggregate rates for group health plans (or employers). This may result in one health plan (or employer) being charged a higher premium than another for the same coverage through the same issuer.

### Can a health insurance issuer charge an employer different premiums for each individual within a group of similarly situated individuals based on each individual's health status?

No. Issuers may not charge or quote an employer or group health plan separate rates that vary for individuals (commonly referred to as "list billing") based on any of the health factors.

This does not prevent issuers from taking the health factors of each individual into account when establishing a blended, aggregate rate for providing coverage to the employment-based group overall. The issuer may then charge the employer (or plan) a higher overall rate, or a higher blended per-participant rate.

While HIPAA prohibits list billing based on health factors, it does not restrict communications between issuers and employers (or plans) regarding the factors considered in the rate calculations.

### Can a group health plan impose a nonconfinement clause (e.g., a clause stating that if an individual is confined to a hospital at the time coverage would otherwise take effect, coverage would not begin until that individual is no longer confined)?

No. A group health plan may not deny or delay an individual's eligibility, benefits, or the effective date of coverage because that individual is confined to a hospital or other health care facility. In addition, a health plan may not set an individual's premium rate based on that individual's confinement.

### Can a group health plan impose an "actively-at-work" provision (e.g., a requirement that an employee be actively at work after a waiting period for enrollment in order to have health coverage become effective on that day)?

No. Generally a group health plan may not refuse to provide benefits because an individual is not actively at work on the day that individual would otherwise become eligible for benefits. However, plans may have actively-at-work clauses if the plan treats individuals who are absent from work due to a health factor (for example, individuals taking sick leave) as if they are actively at work for purposes of health coverage.

Plans may require individuals to report for the first day of work before coverage may become effective. In addition, plans may distinguish among groups of similarly situated individuals in their eligibility provisions. For example, a plan may require an individual to work full time, such as 250 hours per quarter or 30 hours per week, to be eligible for health plan coverage.

### Is it permissible for a group health plan that generally provides coverage for dependents only until age 25 to continue health coverage past that age for disabled dependents?

Yes, a plan can treat an individual with an adverse health factor more favorably by offering extended coverage.

## Nondiscrimination and Wellness Programs

In January 2001, the U.S. Departments of Health and Human Services, Labor, and the Treasury issued proposed regulations on wellness programs under HIPAA. Under the proposed rules, there are criteria for wellness programs that provide a reward based on the ability of an individual to meet a standard that is related to a health factor, such as a reward based on the outcome of a cholesterol test. "Participatory wellness programs," which provide rewards (such as reimbursement for local health club membership, waiver of deductible on prenatal care and well baby visits, free nicotine patches to individuals who want to quit smoking, or free educational material and 24-hour nurse advice line) regardless of an individual's ability to meet a standard related to a health factor, are not required to satisfy the criteria set forth in the proposed rule.

Until further guidance is issued, the Federal Government will not take any enforcement action against a plan or issuer that complies with a good faith interpretation of the statutory provisions relating to wellness program provisions. Of course, compliance with the proposed regulations constitutes good faith compliance with the statutory wellness program provisions.

For updates on the proposed regulation, periodically check www.dol.gov/ebsa under "Laws & Regulations."

### How do the wellness program rules apply to a group health plan's program that offers a reward to individuals who participate in voluntary testing for early detection of health problems? The plan does not use the test results to determine whether an individual receives a reward or the amount of an individual's reward.

The rules do not apply because the plan's wellness program does not base any reward on the outcome of the tests.

### Can a plan provide a premium differential between smokers and nonsmokers?

The plan is offering a reward based on an individual's ability to stop smoking.

Medical evidence seems to suggest that smoking may be related to a health factor. *The Diagnostic and Statistical Manual of Mental Disorders*, which states that nicotine addiction is a medical condition, supports that position. In addition, a report of the Surgeon General adds that scientists in the field of drug addiction agree that nicotine, a substance common to all forms of tobacco, is a powerfully addictive drug.

For a group health plan to maintain a premium differential between smokers and non-smokers and not be considered discriminatory, the plan's nonsmoking incentive would need to meet the criteria in the proposed regulation for a wellness program.

Under the proposed rules, there are four required criteria for wellness programs that require an individual to meet a standard related to a health factor:

- The total reward that may be given to an individual is limited. The proposed regulations invited comments on the appropriate level of the reward, suggesting a limit of 10 to 20 percent of the total cost of employee-only coverage may be appropriate.

- The wellness program must be reasonably designed to promote good health or prevent disease for individuals who participate. (For this purpose, the program must allow individuals an opportunity to qualify for the reward at least once each year.)

- The reward must be available to all similarly situated individuals. Specifically, the program must allow any individual for whom it is unreasonably difficult due to a medical condition to meet the wellness program standard (or for whom it is medically inadvisable to attempt to meet the wellness program standard) an opportunity to satisfy a reasonable alternative standard.

- All plan materials describing the terms of the program must disclose the availability of a reasonable alternative standard.

Accordingly, under the proposed rules, this wellness program would be permitted if:

- The premium differential is not more than 10 to 20 percent of the total cost of employee-only coverage;

- Individuals are given an opportunity to qualify for the discount at least once per year;

- The program accommodates individuals for whom it is unreasonably difficult to quit using tobacco products due to addiction by providing a reasonable alternative standard (such as the discount in return for attending educational classes or for trying a nicotine patch); and

- Plan materials describing the program describe the availability of a reasonable alternative standard to qualify for the lower premium.

# Applying and Enforcing HIPAA; State Flexibility

### Are certain benefits exempt from HIPAA's portability requirements?

HIPAA does not apply to plans with respect to their provision of "excepted benefits." Likewise, if an individual provides evidence of prior health coverage under a plan that provides only excepted benefits, this coverage is not considered creditable coverage.

Some benefits, such as accidental death and dismemberment benefits, are always excepted benefits and are not subject to HIPAA. Other benefits, including (1) limited-scope dental and limited-scope vision benefits, (2) benefits under a health flexible spending arrangement, (3) noncoordinated benefits, and (4) supplemental benefits may be excepted if certain criteria are met.

More specific information on dental-only and vision-only coverage is provided in the following question. For more information on other types of excepted benefits, see 29 CFR 2590.732(c) or contact the EBSA office nearest you.

### Are dental-only and vision-only coverage subject to HIPAA?

It depends. These benefits may constitute limited-scope excepted benefits (and, therefore, are not subject to HIPAA) if:

- The benefits are offered under a separate insurance policy, certificate, or contract of insurance. (This is an option for insured plans only.)

  OR

- The benefits are "not an integral part of the plan." (This is an option for both insured and self-insured plans.) Benefits are not an integral part of the plan if:
  - Participants have the right to elect not to receive coverage for the benefits; and
  - Participants that do elect to receive coverage for the benefits must pay an additional premium or contribution.

### Can States modify HIPAA's portability requirements?

Yes, in certain circumstances. States may impose stricter obligations on health insurance issuers in the seven areas in the following list. States may:

- Shorten the 6-month “look-back period” prior to the enrollment date to determine what preexisting conditions may be subject to the preexisting condition exclusion;

- Shorten the 12- and 18-month maximum preexisting condition exclusion periods;

- Increase the 63-day significant break in coverage period;

- Increase the 30-day period for newborns, adopted children, and children placed for adoption to enroll in creditable coverage without a preexisting condition exclusion;

- Expand the circumstances in which a preexisting condition exclusion period may not be applied;

- Require additional special enrollment periods; and

- Reduce the maximum HMO affiliation period to less than 2 months (3 months for late enrollees). (An affiliation period is the maximum period of time that must pass before coverage provided by an HMO becomes effective. HMOs that impose an affiliation period cannot impose a preexisting condition exclusion period.)

In addition, State laws related to health insurance issuers generally continue to apply except to the extent that such State law “prevents the application of” a requirement of Part 7 of ERISA. Therefore, if health coverage is offered through an HMO or an insurance policy, check with your State insurance department for more information on that State’s insurance laws.

## Who enforces the HIPAA portability provisions?

The Secretary of Labor enforces these requirements under ERISA for group health plans. In addition, participants and beneficiaries can sue both plans and issuers to enforce their rights under ERISA, as amended by HIPAA.

The Secretary of the Treasury also enforces these requirements for group health plans. A taxpayer that fails to comply may be subject to an excise tax.

States also have enforcement responsibility, including sanctions available under State law, for requirements imposed on health insurance issuers. If a State does not act in the areas of its responsibility, the Secretary of Health and Human Services may make a determination that the State has failed “to substantially enforce” the law, assert Federal authority to enforce, and impose sanctions on insurers as specified in the statute, including civil monetary penalties.

# Guaranteeing Employers the Availability and Renewability of Group Health Coverage

### Does HIPAA require health insurance issuers to make health coverage available to small employers?

Yes. Under the PHS Act, small firms (50 or fewer employees) are guaranteed access to health insurance. For more information contact your State insurance department.

### How does HIPAA affect group health coverage renewal and termination?

A group health plan that is a multiemployer plan or multiple employer welfare arrangement (MEWA) generally may not deny an employer whose employees are covered under that plan continued access to the same or different coverage. This rule does not apply if the plan no longer offers service or has any providers in a geographic area. In addition, this rule would not apply where an employer:

- Fails to make payment of contributions;
- Commits fraud or other intentional misrepresentation of material fact;
- Fails to comply with a material plan provision; or
- Fails to meet the terms of, renew, or employ workers covered by a collective bargaining agreement.

In addition, for all group health plans, the PHS Act requires that, at an employer's option (as the plan sponsor), the issuer offering the group health insurance coverage must renew or continue in force the employer's current coverage. However, the issuer may discontinue insurance coverage when:

- Premiums are not paid or are not paid timely;
- Fraud is committed;
- Participation or contribution rules are violated;

- The issuer ceases to offer that particular coverage or all health insurance coverage;

- All individuals move outside the service area; or

- Membership in a bona fide association ceases.

For more information contact your State insurance department.